69-1004-4625-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF COMMERCE

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| In the Matter of the Insurance Agent's License of Raymond R. Rew | FINDINGS OF FACT, CONCLUSIQNS AND RECOMMENDATION |

The above-entitled matter came on for hearing before Administrative Law Judge Steve M. Mihalchick on June 7, 1990, at 10:00 a.m. and continued on June 8, 1990, at 9:30 a.m. in the courtroom of the Waseca County Courthouse, 307 North State Street, Waseca, Minnesota.

Karyn M. (Kim) Greene, Special Assistant Attorney General, 1100 Bremer Tower, Seventh Place and Minnesota Street, St. Paul, Minnesota 55101, appeared on behalf of the Department of Commerce. Kevin D. Riha, Attorney at Law, 114 South State Street, Waseca, Minnesota 56093, appeared on behalf of the Licensee, Raymond R. Rew. The record closed on August 24, 1990, upon receipt of the Department's Reply Brief.

This report is a recommendation and not a final decision. The Commissioner of Commerce will make the final decision after reviewing the record and may adopt, reject or modify the Findings of Fact, Conclusions and Recommendation made in this report. Under Minn. Stat. 14.61, the Commissioner shall not make a final decision until this report has been made available to the parties to the proceeding for at least ten days. Each party adversely affected by this report must be afforded the opportunity to file exceptions and present argument to the Commissioner. Parties should contact Thomas H. Borman, Commissioner, Minnesota Department of Commerce, 133 East Seventh Street, St. Paul, Minnesota 55101, to inquire about the procedure for filing exceptions or presenting argument.

## STATEMENT OF ISSUES

1. Whether Licensee, in connection with the sale of a replacement Medicare Supplement policy to Mrs. Delia Krienke (Krienke):

   a. Illegally duplicated medicare supplement coverage in violation of Minn. Stat. 62A.43, subd. 1. (Count I.)

   b. Illegally replaced a Medicare supplement plan with another in the same category in violation of Minn. Stat. 62A.40. (Count II.)

c. Recommended the purchase of a Medicare supplement policy to a customer without reasonable grounds for believing the recommendation was

suitable and without making reasonable inquiries to determine suitability in violation of Minn. Rules pt. 2795.0900. (Count III.)

d. Made false statements to Krienke regarding the coverage provided by her existing policy he knew or should have known were false and thereby failed to observe high standards of commercial honor in violation of Minn. Rules pt. 2795.1000. (Count VII.)

2. Whether Licensee made false statements under oath in connection with the investigation of the Krienke matter and thereby failed to observe high standards of commercial honor in violation of Minn. Rules pt. 2795.1000. (Count VI.)

3. Whether Licensee was a supervising agent and, if so, whether he failed to establish, maintain and enforce written procedures to ensure proper supervision of the activities of agents he supervised and compliance with insurance laws and rules in violation of Minn. Rules pt. 2795.0800, subp. 2. (Count V.)

4. Whether Licensee distributed flyers to senior citizens regarding informational meetings he conducted that did not prominently identify the insurance company or prominently communicate that the primary purpose of the meetings was to identify insurance prospects or the sell insurance in violation of Minn. Rules 2790.0500, subp. 33, B, C, D and E and has disseminated to the public a notice or circular containing as assertion, representation or statement with respect to the business of insurance which is untrue, deceptive or misleading in violation of Minn. Stat. 72A.20, subd. 2. (Count VIII.)

Based upon the record herein, the Administrative Law Judge makes the following:

## FINDINGS OF FACT

1. Licensee has been an insurance agent licensed in Minnesota since February 1986. Licensee has been a sales associate with American Family Life Assurance Company (AFLAC) from February 1986 until June or July 1986, and from February 1989 through the present time. From June or July 1986 to February 1989, he was also a District Sales Coordinator with AFLAC. He has sold Medicare supplement insurance policies for two to three years.

2. As an AFLAC sales associate, Licensee had an agreement with Demographic Marketing Techniques, Inc. (DMT) (Ex. 11) to supply him with leads on senior citizens who were Medicare recipients and who had Medicare supplement policies coming up for renewal within 90 days or who had no such policy. It was a policy of AFLAC that their policies only be sold to such persons. DMT is a Waseca area telemarketing firm that began doing business on February 15, 1989, and went out of business on December 31, 1989. Two AFLAC District Sales Coordinators (other than Licensee), the Regional Sales Coordinator, the State Sales Coordinator and Jeffrey Kuechenmeister, who ran

the company, owned all the stock in DMT during the time of the sale in question.

3. Under the DMT agreement, DMT agreed to obtain fifteen appointments each week for each associate and each associate agreed to make sales to a minimum of 25% those appointments. Twenty percent of the commission on each of those sales was paid to DMT and 80% goes to the associate.

4. DMT employees worked from a script that, after April 27, 1989, was in a form that had been reviewed by the Department (Ex. 10), making calls to senior citizens and obtaining appointments for the next day or two for AFLAC associates. Information obtained from these contacts was recorded on a form (like Ex. C). In the evening, the DMT manager contacted the associates with their appointments for the next day. The associates recorded the information on the same type of form and returned it to DMT, along with a Commission Split Agreement, if a sale was made (Exs. 33 and E).

5. DMT made four appointments in Waterville, Minnesota, for Licensee for Tuesday, May 9, 1989. Waterville is 12 miles north of Waseca. Licensee was scheduled to see Krienke at 3:30 p.m. That appointment was set up by a DMT employee, Richard Lassahn. He provided information on the contact sheet indicating that Krienke wanted an explanation of certain Medicare changes (this was the thrust of the telemarketing script), that she had a Medicare supplement policy that was coming due soon and that she paid her premium on the policy semiannually. (Ex. C)..

6. Licensee visited Krienke, then age 79, at her home at 701 No. First Street in Waterville, Minnesota, at about 3:30 p.m. on May 9, 1989. He had neither met Krienke nor spoken with her before this visit. He identified himself and that he was an insurance agent. Krienke knew that he was selling insurance. They sat at her dining room table where Licensee began talking about Medicare benefits. At the time of Licensee's visit, Krienke's husband had been in a nursing home for about two years. He died three months later. Krienke had managed all of the couple's finances because she was better able to do so.

7. Krienke had a Category 3 Medicare supplement policy with Guarantee Trust Life Insurance Company. Her GTL policy had been purchased on November

2, 1988, for an annual premium of $551.00 plus a $20.00 fee and was effective from December 30, 1988, to December 30, 1989. On Medicare Part A (hospitalization), the policy paid the Medicare Part A deductible ($540.00 in 1988 and $560 in 1989). On Medicare Part B (medical services and supplies), after a $200 annual deductible, the GTL policy paid the greater of 95% of the difference between what Medicare paid and the "Usual and Customary Charges" for those services or 20% of the Medicare approved charges.

8. With regard to Part B, Medicare limits its payments to 80% of what it approves as a "Reasonable Charge." It also has an annual deductible, which was $75.00 during the period relevant here. The patient must pay the difference between what the physician or other provider charges and what Medicare pays, or obtain Medicare supplement insurance to cover all or some of the difference. In Licensee's experience in the Waseca area, Medicare approved charges have ranged from 55 to 72% of the billed charges. Wider variations are possible.

9. Under the GTL policy, "Usual and Customary Charges" were defined as the smaller of the customary charge made by that provider for the service or

the general level of the charges for comparable services by other providers in the locality (Ex. 19). Many policies use the concept of "usual and customary charges" as a limit. In practice, that generally means that insurers keep some kind of book of rates for each locality of average charges for various services and apply that as a limit. The Department requires that the "Usual and Customary" limit be established at at least the 50th percentile of all providers' charges, but some insurers set it higher. It is impossible to tell what the limit for a particular claim is from reading a policy. An investigator from the Department called the claims supervisor at GTL and was told that GTL would assume that the "usual and customary charge" was equal to the provider's bill if the bill was less than $1000 or if it was greater than $1000 but less than twice the Medicare approved amount. The claims supervisor also said that if such a bill was more than twice the Medicare approved amount, GTL would write the provider for an explanation and, if they found it acceptable, approve it as the "usual and customary charge." GTL claimed that it thus accepted the billed amount as the usual and customary charge 99% of the time.

10. The AFLAC Medicare supplement policy sold by Licensee in 1989 had a somewhat different approach than the GTL policy with regard to Part B coverage. It paid the 20% of the Medicare approved charge that Medicare did not pay, less the $75 Medicare annual deductible, plus 100% of the difference between the Medicare approved amount and 150% of that amount. In other words, the AFLAC limit was one and one-half times the Medicare approved amount. The effect of this limit was that if the Medicare approved amount was more than two-thirds of the billed amount, AFLAC would pay 100% of the claim (after the $75 deductible). If the Medicare approved amount was less than two-thirds of the billed amount, then the payment was something less. The AFLAC policy covered the Part A Medicare deductible like the GTL policy, but unlike the GTL policy, offered an accidental death benefit of $1000 for each year the policy was in effect.

11. It was Licensee's practice to always use the same hypothetical to explain AFLAC's Part B coverage. That hypothetical was a $10,000 doctor bill of which Medicare approved 70%, or $7,000. Since Medicare pays 80% of the approved amount, in the hypothetical it would pay $5,600, leaving $4,400 that

it did not cover. Licensee called the difference between the Medicare approved amount and the actual bill the "excess," which would be $3,000 in the hypothetical. Under this hypothetical, and ignoring the $75 deductible, AFLAC would pay the 20% of the approved amount not paid by Medicare, or $1,400, and all of the excess of $3000, for a total of $4,400.

12. The foregoing hypothetical is the best case for the AFLAC policy. Because the Medicare approval rate is 70% in the hypothetical, it results in AFLAC paying all of the amount not paid by Medicare. It also demonstrates a fairly large unapproved amount. This is the hypothetical that AFLAC gives to its associates in their training and, by coincidence, is about the same as a claim experienced by Licensee's wife's grandmother, so he was able to personalize the example. If the hypothetical had a Medicare approval rate of something less than two-thirds, the result would be different. For example, if the approval rate was 60%, the approved amount would be $6000 of which Medicare would pay 80%., or $4800, leaving $5200 unpaid. AFLAC would pay the difference between 150% of the approved amount ($9000) and the approved amount ($6000), or $3000, plus the 20% not paid by Medicare, or $1200, for a total of

$4200. Thus, $1000 of the doctor's bill would still have to be paid by the insured. Licensee did not give such examples in his normal presentation because, he claimed, it was too confusing, Obviously, he did not do so because it was not so flattering to AFLAC. He would only use the standard hypothetical unless the customer had a recent claim of their own that he could use to demonstrate what AFLAC would have paid.

13. Under the GTL policy, if the charge for a Part B service was $10,000 and Medicare approved $7000 and paid $5600, GTL would pay a maximum of 95% of $4400, or $4180. This is $220 less than AFLAC would pay and might be even less if GTL's usual and customary charge for the service was less than $10,000. If Medicare approved 60%, GTL would pay a maximum of 95% of $10,000 minus $4800, or $4940. That is $740 more than AFLAC, but could be less if the usual and customary charge for the service was less than $10,000. Thus, it cannot be said that the AFLAC coverage is better than GTL's; in many cases it is worse.

14. Licensee engaged in a few minutes of small talk with Krienke, then began explaining some things about Medicare to her using a Medicare pamphlet. He then described the AFLAC coverage using the 70% hypothetical. Licensee knew that Krienke already had a Medicare supplement policy and ask her to get the policy for him to compare. She went to the desk in her bedroom where she kept her important papers and returned with the GTL Outline of Coverage (Ex. 3) and her Long Term Care Insurance policy. Licensee asked her to look again for the GTL policy, but Krienke said that was all she had, probably because she didn't care to look again. Licensee saw that the Long Term Care policy had been issued by a Wisconsin agent. He learned from Krienke that the agent that sold her the GTL Medicare supplement was from "up near the Cities." As part of his presentation he emphasized that he was a local agent who would personally handle her claims and take care of her. He called the Department from Krienke's home to see if the Wisconsin agent was licensed in Minnesota, apparently to emphasize his caring service, and was informed that the agent

was licensed in this state. He informed Krienke that AFLAC was working on a Long Term Care policy, but that it was not ready yet.

15. Using the Outline of Coverage to evaluate the GTL policy, Licensee told Krienke that the AFLAC coverage was better. It is not clear what he said to demonstrate that claim. The AFLAC coverage was not better than the GTL coverage and Licensee knew that or should have known that. The Outline of Coverage indicates that coverage of the Part A deductible was the same. With regard to Part B, the Outline of Coverage indicates that after a $200 deductible, the policy pays 95% of the difference between the Usual and Customary Charge and what Medicare pays. That might have been read by Licensee as a $200 deductible on each claim, although the policy itself makes clear that it is an annual deductible (Ex. 19). But even if there was a $200 deductible each time, the GTL policy would still pay more if the Medicare approval rate was less than 67%, which it often was. The only basis for a contrary conclusion would be if the Usual and Customary Charge were less than the billed amount. That was not, in fact, the case here and Licensee had little basis for making such an assumption. The only quantifiable difference between the policies was that AFLAC provided $1000 worth of accidental death coverage. That is not particularly valuable.

16. In March of 1989, Conrad Kerber, the agent who had sold Krienke the GTL policy, had returned to sell her life insurance. At that time she had asked him when her payment was due on her Medicare supplement plan. When DMT and Licensee called upon her, Krienke was unsure of whether her GTL premium had been paid for a whole year and when the next payment was due. Krienke and Licensee looked at her checkbook register and found she had recorded a $571 amount on November 2, 1988, but had made no notation as to whether it was an annual or semi-annual payment (Ex. 20). The Outline of Coverage of the GTL policy only indicated that the initial premium for the policy had been $571.00. The Outline of Coverage has no place to indicate the period that the initial premium covered and Kerber had made no such indication on the form. The form does contain spaces for renewal premiums that indicate the frequency of payment, but those were not filled in. Licensee assumed that Krienke had paid a semi-annual premium because that is what DMT had told him, because Krienke probably reaffirmed that and because the premium of $571 seemed like a low amount for an annual premium because, in his experience, the AFLAC policy and the GTL policy generally had comparable premiums. Licensee took no action to verify his assumption.

17. Having concluded that Krienke had paid a semi-annual premium in November, he figured that her next premium was due in about June. Licensee may have told Krienke that her GTL policy covered her into July and, with the one-month grace period given on all policies, she would be covered during the ninety-day exclusion for pre-existing conditions under the AFLAC policy. Licensee had some sort of conversation with Krienke regarding pre-existing conditions because it was on the application form and the notice regarding replacement forms that he reviewed with Krienke and had her sign. But he probably concluded that there already was a two-month overlap, so no additional premium was necessary. Krienke would certainly have recalled being told to pay an additional premium to GTL, which she does not.

18. Based solely on Licensee's representation that his policy provided "better coverage," Krienke purchased the AFLAC policy for an annual premium of $943.25, plus a $10 fee. It was effective from May 15, 1989 to May 15, 1990 (Ex. 6). Licensee completed an AFLAC replacement form (Ex. 2) for Krienke's signature on the day of the sale. He marked the box on the form indicating that the reason for replacement was that the AFLAC policy provided significantly higher benefits. Licensee believed that the biggest selling point for Krienke was that he was a local agent and that he was "next door" if she had a claim.

19. Krienke had expressed no dissatisfaction with her GTL policy to Licensee. She purchased the AFLAC policy because she had been led by him to understand that it would provide better coverage. She signed the AFLAC

application form (Ex. 1) which had been completed by Licensee. At the time of the sale, Licensee knew that Krienke had a category 3 Medicare supplement because the GTL Outline of Coverage included a deductible and all category 3 policies have deductibles. He knew that he was replacing her GTL policy with another category 3 policy.

20. In August 1989, Krienke was visited by Kerber, the independent insurance agent who had sold her the GTL policy, and his brother, the insurance broker for whom he worked. This visit was shortly after Krienke's husband had died; Kerber found her very upset at the time. She was also

visibly upset recalling this situation during the hearing. She mentioned to Kerber that she had changed policies. He knew that she had paid a full year's premium, looked at the AFLAC policy, and noticed that it had a May effective date. He and his brother then assisted Krienke in drafting a complaint letter to the Department.

21. In a letter from the Department dated September 14, 1989, Licensee was asked to explain why he thought the AFLAC policy was suitable for Krienke (Ex. 7). His response, drafted by his attorney and reviewed by Licensee, included a statement that the GTL policy would pay 80% of the Medicare approved amount and nothing on the excess between the actual billed cost and the amount that Medicare paid (Ex. 9). This response was clearly in error and has no basis in the GTL policy or Outline of Coverage. This was probably an oversight or misstatement and should have said, '"20%", because Licensee later claimed that to be the case, also in error.

22. On December 15, 1989, Licensee gave a statement under oath to Department investigator. In that statement, he described the coverage for doctor bills under her GTL policy with the coverage under the AFLAC policy (Ex. 22). He correctly stated that AFLAC would pay 100% of the excess charges, the difference between the Medicare approved charge and the actual bill, unless Medicare approved less than 68% of the actual bill. He incorrectly stated that the GTL policy would pay only the 20% of the approved charge that Medicare did not pay and that GTL would pay none of the difference between the approved amount and the billed amount.

23. In that same statement, Licensee also stated that he determined that Krienke's premium on the GTL policy was semi-annual because at her age the annual premium should have been between $800 and $1,000 and that the Outline of Coverage had said her premium was $400 or $500. He claimed that he saw nothing on the GTL Outline of Coverage (Ex. 3) regarding GTL paying 95% of the difference between the amount paid by Medicare and the usual and customary charge for the service, but only saw a box checked indicating that it paid 20% of the approved charge. There is no such box on that form and the 95% language is obvious. At the end of his statement, Licensee did point out, in response to a question from the investigator indicating that he felt the only difference between the policies was between the 95% coverage offered by GTL and the possible 100% offered by AFLAC, that the 95% was of usual and

customary charges. Licensee then went on to explain to the investigators what usual and customary charges were and that how they could be less than the billed amounts and claimed that 95% of usual and customary could be significantly less than AFLAC's 100% coverage of certain claims. He also stated that he felt it appropriate to replace a category 3 Medicare supplement with another category 3 if the replacement can provide more coverage and that he understood the statute to allow replacement for either a cost savings or more coverage. He stated specifically that the reason he replaced her policy was because of greater coverage. Licensee also stated that he advised Krienke to make monthly payments to GTL for two months to cover any pre-existing condition.

24. On April 26, 1990, Licensee gave a deposition. In that deposition, he described the sales presentation he made to Krienke and how he compared the coverage for doctor bills under the two policies. Using his standard hypothetical, he stated that the AFLAC policy would pay 100% of the excess

charges while the most that the GTL policy would pay would be 95% (Ex. 21, at 55-56).

25. In his deposition, Licensee also stated that he determined that Krienke's GTL premium was paid semi-annually and, therefore, he would be saving her $148 in premiums each year and $125 in a lower deductible each year with the AFLAC policy (Ex. 31, p. 65). He claimed that in replacing a category 3 Medicare supplement with another category 3, he was giving her "slightly more benefits in some cases . . . and less premium." (Ex. 21, at 79-80).

26. In his deposition, Licensee also stated, with regard to the need for overlap to cover any pre-existing condition, that she would not have to extend her GTL policy beyond June; that double coverage for part of May and the entire month of June would be sufficient. He denied that he ever told her that she would need to continue her GTL policy. Licensee also stated that she had no pre-existing condition and, therefore, there was no need to keep her policy in effect after June 30, 1989 (Ex. 21, p. 78).

27. Between January 31, 1988, and February 14, 1988, Licensee's license was suspended. This suspension came about as a result of his participation in the sale of a Medicare supplement-policy which replaced and overlapped an existing policy in an illegal manner. At the time of that sale, Licensee was training in a new associate, was acting as her manager, and was responsible for her actions. Licensee claims that the new associate had made the presentation while he watched; the new associate claims that he made the presentation while she watched (Ex. 32). Licensee waived his right to a hearing and agreed to the two-week suspension, without admitting or denying the allegations, under a Consent Order issued by the Department (Ex. 12).

28. Within the AFLAC structure, an associate is a licensed insurance agent who enters into an Associate's Agreement with the company (Ex. A). Under the terms of the agreement, the associates' relationship with AFLAC is that of an independent contractor (Ex. A, Paragraph One). Commissions are paid to associates as their full compensation with the amount determined according to a schedule of commissions (Ex. A, Paragraphs Four through Six). They are not reimbursed for business expenses. AFLAC does not withhold state or federal income taxes on the commissions, does not pay workers' compensation, nor require that associates work during specified hours. Associates are not authorized to interpret policy language. They are authorized to solicit applications, collect initial premiums, and direct both the application and premium collected to AFLAC (Ex. A, Paragraph Two). An associate is in field training during the initial 90 days, works with a District Sales Coordinator, and makes sales presentations under the District Sales Coordinator's supervision. Training beyond the first 90 days is on-going, but irregular with the extent and frequency of such training dependent upon the individual associate's motivation and ability to continue to make sales. Associates have no agents working under them.

29. In late 1988 or early 1989, AFLAC established a nationwide policy requiring that associates report their sales activities to their District

Sales Coordinator three times'each week. This reporting is done on Monday, Wednesday, and Friday evenings. It consists of the number of presentations made, the number of calls on prospective clients, and the number of sales.

Licensee has reported in this manner since he resumed an associate position in February 1989. Prior to 1989, the practice was to report weekly.

30. Within the AFLAC structure, an associate may also become a District Sales Coordinator by entering into another agreement with the company (Ex. B). A District Sales Coordinator is responsible for recruiting and training associates, coordinating their activities (Ex. B, Paragraph Three), and for motivating them in their production efforts. Recruitment includes assisting with hiring new associates by locating candidates, interviewing them and selecting them in conjunction with the Regional Sales Coordinator.

31. The District Sales Coordinator's relationship with AFLAC is also that of an independent contractor. District Sales Coordinators are not reimbursed for their business expenses. They receive first year and renewal override commissions on the sales of associates under them as full compensation (Ex. B, Paragraph Five). The overrides are paid, in part, to cover their management expenses related to recruitment and training. They continue to be paid even after the recruiting and training of a particular associate has been completed for as long as the associate is assigned to the District Sales Coordinator.

32. Licensee was a District-Sales Coordinator for approximately three and one-half years. During that time he had eight to ten associates working under him. These associates made production reports to him weekly, and he provided training regarding AFLAC products and presentation methods on an as-needed basis. Licensee talked with his associates about the laws on overlapping and replacing Medicare supplement policies. He had copies of the replacement, overlap, and suitability statutes in his office (Ex. 21, p. 9). He shared his knowledge of the statutes with those associates to assure that their sales presentations were ethical and in compliance with Minnesota Law (Ex. 21, p. 9). Licensee did not establish any written procedures to ensure compliance with insurance laws and rules.

33. In early 1988, Licensee was informed by the Department that it had received a complaint regarding a flyer, Ex. 13. It was being distributed by

Licensee announcing Medicare informational meetings for senior citizens and identified him only as "Ray R. Rew and Associates." The flyer did not identify Licensee as an insurance agent, did not identify any insurer, did not state that it was an advertisement for insurance or intended to identify insurance prospects, and did not state that Licensee was not connected with the federal Medicare program. Those who attended the meetings registered for a door prize by placing their names on a piece of paper. Licensee used the names as leads, but informed those at the meeting that he would not do so if they came up and asked to have their names removed after the drawing.

34. The first flyer was modified in response to the demands of the Department (Exs. 15, 16 and 17). The modified flyer showed "Ray R. Rew and Associates" above "American Family Life Assurance Co., District Sales Coordinator, Medicare Supplement Division." It did not state that the purpose of the meeting was to sell insurance or identify prospects. Nonetheless, Michael LeTourneau, a Department investigator, informed Licensee's attorney that the modified flyer appeared to meet the requirements of the law. He testified to the same effect at the hearing. Licensee and his attorney took

this to mean that the Department approved the flyer, but the Department never actually "approves" any such document according to Mr. LeTourneau.

35. A third flyer came to the Department's attention in December 1989, along with a complaint from an insurance agent (Ex. 18 and Ex. 27). The flyer heading and date are comparable to the "approved" flyer. Information as to the purpose of the meeting, times and location are in smaller type, but equally as prominent as the type identifying "Ray Rew and Associates," and "American Family Life Assurance Co. of Columbus" and that a free copy of the Medicare "Bill of Rights" can be picked up at the meeting. A statement that neither AFLAC nor its associates are connected with the federal Medicare program or any other federal or state agency had been added and is in type approximately half the size of most of the other type. Like the "approved flyer, it does not clearly and expressly disclose that Licensee is an insurance agent or prominently state that material or information will be delivered in person by a representative of the insurer.

36. On March 24, 1990, the Commissioner of Commerce issued a Notice of and Order for Hearing and Order to Show Cause, setting forth Counts I through III. On May 10, 1990, the Commissioner issued an Amended Notice and Order for Hearing and Order to Show Cause, adding Counts IV through VII. On May 25, 1990, the Commissioner issued a Second Amended Notice of and Order for Hearing and Order to Show Cause, adding Count VIII. Count IV, which had alleged that Licensee had violated the disclosure requirements of Minn. Stat. 60A.17, subd. 18, by not revealing to Krienke that he was an insurance agent, was dismissed at the hearing upon joint motion of the parties.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

## CONCLUSIONS

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. 60A.17, subds. 6, 6c, and 6d, 45.027, subd. 7, and 14.50.

2. The Department of Commerce has fulfilled all relevant substantive and procedural requirements of law or rule and has given proper notice of the hearing in this matter.

3. Under Minn. 60A.17, subd. 6c(a), the Commissioner may suspend or revoke an insurance agent's license or impose a civil penalty not to exceed $5,000 if the following conditions, among others, exist:

> (2) Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issurance;
>
> (3) Violation of, or non-compliance with, any insurance law or violation of any rule or order of the commissioner or of a commissioner of insurance of another state or jurisdiction;
>
> (6) Misrepresentation of the terms of any actual or proposed insurance contract;

(9) That in the conduct of the agent's affairs under the license, the licensee has used fraudulent, coercive, or dishonest practices, or the licensee has been shown to be incompetent, untrustworthy, or financially irresponsible.

4. Minn. Stat. 62A.43, subd. 1 provides:

> No agent shall sell a Medicare supplement plan, as defined in Section 62A.31, to a person who currently has one plan in effect; however, an agent may sell a replacement plan in accordance with Section 62A.40, provided that the second plan is not made effective any sooner than necessary to provide continuous benefits for preexisting conditions. Every application for Medicare supplement insurance shall require a listing of all health and accident insurance maintained by the applicant as of the date the application is taken.

Minn. Stat. 62A.40 provides:

> No insurer or agent shall replace a Medicare supplement plan with another Medicare supplement plan of the same category unless there is a substantial difference in cost favorable to the policy holder, or the insured has previously demonstrated a dissatisfaction with the service presently being received from the current insurer. An insurer or agent may replace a Medicare supplement plan with a less comprehensive plan only if the prospective insured signs an acknowledgement that it is understood that the prospective insured will receive less benefits under the new policy than under the policy presently in force.

5. By selling Krienke a replacement Medicare supplement policy that overlapped her existing GTL policy by 7 1/2 months, Licensee has violated the provisions of Minn. Stat. 62A.43, subd. 1. The AFLAC policy had a ninety-day exclusion for pre-existing conditions and the overlap far exceeded that. Moreover, Krienke had no pre-existing condition that would justify any overlap even if her policy had, in fact, expired within 90 days of May 15, 1989. Pursuant to the provisions of Minn. Stat. 60A.17, subd. 6c(a)(3) discipline may be imposed upon Licensee for such violation. Moreover, by selling such a policy Licensee has shown himself to be incompetent or untrustworthy and is subject to discipline under Minn. Stat. 60A.17, subd. 6c(a)(9).

6. By selling Krienke a replacement Medicare supplement policy that did not have a substantial difference in cost favorable to Krienke and when she had not previously demonstrated any dissatisfaction with the service being received from her current insurer, Licensee has violated Minn. Stat. 62A.40

and has demonstrated himself to be incompetent or untrustworthy and is therefore subject to discipline or civil penalty pursuant to Minn. Stat. 60A.17, subd. 6(a)(3) and (9).

7. Neither of the violations set forth in the prior Conclusions requires that the Licensee act knowingly and willfully. In this case, the Licensee was working under the assumption that Krienke had originally paid a semi-annual premium that would have made her policy effective through May or June 1989, and subject to renewal at that time. The Commissioner may consider that fact in determining the appropriate sanction in this matter. However, the Commissioner should also consider the fact that Licensee's assumption was not well founded. It was based on a lack of information and Licensee made no significant effort to determine the true facts.

8. Minn. Rule 2795.0900 states:

> In recommending the purchase of any . . . medicare supplement insurance to a customer, an agent must have reasonable grounds for believing that the recommendation is suitable for the customer, and must make reasonable inquiries to determine suitability. The suitability of a recommended purchase of insurance will be determined by reference to the totality of the particular customer's circumstances, including, but not limited to, the customer's income, the customer's need for insurance, and the values, benefits, and costs of the customer's existing insurance program, if any, when compared to the values, benefits, and costs of the recommended policy or policies.

9. In selling the Medicare supplement replacement policy to Krienke, Licensee violated Minn. Rule 2795.0900. The replacement policy was not suitable for Krienke because it did not provide better coverage, it overlapped her existing policy by 7 1/2 months, and it cost significantly more. Licensee had no reasonable grounds for believing anything to the contrary because, as discussed above, he had no reasonable grounds for his assumption that she had made only a semi-annual payment when she purchased the GTL policy. Licensee did not make reasonable inquiries to determine suitability. He could have asked Krienke to once again look for her policy, although he probably would have been told quite strongly that she didn't have it since she had not returned with it in the first instance. He could have called GTL or he could have called Kerber. He had no reluctance to call the Department to check on the agent who had sold Krienke the long-term care policy when he thought there was a possibility that he might find something that he could use to his advantage or at least to show Krienke how concerned he was about her insurance coverages. But he did not do so and proceeded on the lack of knowledge to sell her the insurance she didn't need contrary to the requirements of the rule. As such, he has also shown himself to be incompetent and untrustworthy and he is therefore subject to discipline or civil penalty pursuant to Minn. Stat. 60A.17, subd. 6c(a)(3) and (9).

10. Minn. Rule 2790.0500, subp. 1, provides:

No advertisement or representation, written or oral, may omit information or use words, phrases, statements, references, or illustrations if the omission of the information or use of the words, phrases, statements, references, or illustrations has the capacity, tendency,

> or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to the prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied does not remedy misleading statements.

Minn. Rule Pt. 2795.1000 provides:

> Every agent must observe high standards of commercial honor and just and equitable principles of trade in the conduct of the agent's insurance business.

11. In describing the AFLAC policy coverage to Krienke, Licensee used an illustration that presents the best case for the AFLAC policy and tends to indicate that it provides 100% coverage. He did not provide any examples where that was not the case, even though it is at least as likely that any particular claim would present a situation in which the AFLAC policy would not provide 100%. coverage. It is not clear what Licensee told Krienke about her existing coverage under the GTL policy. It seems most likely that he saw the statement in the AFLAC coverage that GTL paid 95% of the usual and customary and would have told her, as he did the Department investigators, that usual and customary was usually something lower than the billed amount and that, therefore, 95% of it was usually less than the AFLAC coverage. At any rate, it is clear that he told her the GTL coverage was not as good and that the AFLAC coverage was better. That is a false and misleading statement and deceived Krienke as to the nature of the benefits under the two policies. Such conduct is in violation of Minn. Rule 2790.0500, subp. 1, and, by any standard, is not consistent with high standards of commercial conduct and is in violation of Minn. Rule 2795.1000. Such conduct is fraudulent, coercive and dishonest and shows Licensee to be untrustworthy and therefore subject to discipline or civil penalty pursuant to Minn. Stat. 60A.17, subd. 6(a)(3), (6) and (9).

12. Under Minn. Stat. 60A.17, subd. 6c(a)(2), the Commissioner may impose discipline for any cause under which the license could have been refused at the time of issuance. Minn. Stat. 60A.17, subd. 6, which states the qualifications for licensure, states that a person can be refused licensure if the Commissioner is satisfied that the person is untrustworthy or of bad moral character.

13. Licensee made several statements under oath that were untrue. He gave statements under oath to Department investigators on December 15, 1989, in a deposition on April 26, 1990, and at the hearing in this matter. The Administrative Law Judge believes Licensee's principle claims that he did not see the GTL policy itself, only the Outline of Coverage, and that he was operating under the assumption that Krienke had only paid a semi-annual premium for the GTL policy. But, there were several discrepancies and misstatements throughout the three sworn statements. It is apparent that Licensee was attempting to justify and bolster the reasons for what he did

even though they were not part of his consideration at the time of the sale to
Krienke. He specifically stated in the statement to the investigators that

the reason he sold the policy to Krienke, and a reason he gave to her for buying it, was that it provided better coverage. Later, he claimed that it was because he thought the AFLAC policy cost less. Contrary to the Department's assertion, however, he has consistently claimed that another factor in her decision was that he was a local agent. His explanation about determining that she was taking some type of medication and concluding that she had a pre-existing condition were inconsistent. In one place, he claimed that he told her to renew her policy for two months or thereabouts and in another place he claimed that that would not be necessary because there was already a two-month overlap and the additional thirty-day grace period would take care of any exclusion under the ninety-day pre-existing clause. There are other minor items. For example, in his statement to the investigators, he originally claimed that the Outline of Coverage said that the GTL premium had been between $400 and $500, but acknowledged that it was more when the investigator said he thought it was $551. At the hearing he made various statements about whether it was $551 or $571 and finally seemed to acknowledge that it was $571. These false statements under oath show the Licensee is untrustworthy, that he has engaged in fraudulent and dishonest practices, that he has failed to observe high standards of commercial conduct and is therefore subject to discipline pursuant to Minn. Stat. 60A.17, subd. 6c(a)(2), (3) and (9).

14. Minn. Rule 2795.0100, subp. 8 states:

> "Supervising agent" means an agent or general agent who contracts with, employs or engages one or more agents to solicit applications for insurance, or to otherwise act as insurance agents on the supervising agent's behalf. In the case of an agency required to be licensed under Minnesota Statutes, Section 60A.17, subdivision 1, the supervising agents, if not specifically designated, shall be the licensed officers of the corporate agency, or the partners of a partnership agency.

Minn. Rule 2795.0800, subp. 2, pertains to one of the duties of a supervising agent and requires that:

> A supervising agent must establish, maintain, and enforce written procedures which will ensure proper supervision of the activities of each agent and compliance with insurance law and rules.

15. Licensee was a supervising agent while he was a District Sales Coordinator for AFLAC from July 1986 to February 1989. While the AFLAC system is to employ associates under independent contractor agreements with the company and District Sales Coordinators as independent contractors with the company, the relationship between the District Sales Coordinator and the assigned agents is one of a supervisor and agent. The District Sales Coordinators are responsible for recruiting, hiring and training new associates, for providing continuing training to the agents assigned and for coordinating the activities of those agents. A primary function of the

District Sales Coordinators is to motivate the associates to produce sales for
the company. The District Sales Coordinator receives an override on all of the associates' commissions. At the hearing, Licensee and his current

District Sales Coordinator often referred to the District Sales Coordinator and Regional Sales Coordinators as "managers." The functions performed by the District Sales Coordinators are similar to the functions of supervisors in any business setting. It must be concluded, therefore, that the AFLAC District Sales Coordinators are supervising agents as defined by the rule and that Licensee was therefore a supervising agent during the period he was a District Sales Coordinator.

16. Licensee did not consider himself a supervising agent because under the system established by AFLAC, he had been told he was not a supervising agent. He therefore made no effort to comply with the requirements imposed upon a supervising agent by rule and, in particular, did not establish and maintain written procedures to ensure proper supervision of the activities of the agents he supervised and their compliance with the insurance laws and rules. He did make some informal, oral efforts to do so. Licensee's conduct in failing to maintain such written procedures constitutes a violation of Minn. Rule 2795.0800, subp. 2, and he is therefore subject to discipline or civil penalty pursuant to Minn. Stat. 60A.17, subd. 6(a)(3).

17. Minn. Rule 2790.0500, subp. 33 provides:

> An advertisement which offers to provide information concerning the federal Medicare program or changes in that program must:
>
> A. include no reference to the program on the envelope, the reply envelope, or on the address side of the reply postal card, if any;
>
> B. include on any page containing a reference to the program on equally prominent statement to the effect that in providing supplemental coverage the insurer and agent involved in the solicitation are not in any manner connected with the program;
>
> C. contain a statement that it is an advertisement for insurance or is intended to obtain insurance prospects;
>
> D. prominently identify the insurer or insurers which will issue the coverage; and
>
> E. prominently state that any material or information

offered will be delivered in person by a representative of the insurer, if that is the case.

18. The senior citizen meeting flyer distributed by Licensee late in 1989 for meetings he conducted at that time does not comply with all of the requirements of the rule because it does not contain a specific statement that it is an advertisement for insurance or intended to obtain insurance prospects and does not state that any material will be delivered by a representative of the insurer. However, it is concluded that this violation does not constitute a basis for discipline under Minn. Stat. 60A.17, subd. 6c(a)(3) or (9). This flyer is more in compliance with the rule then the previous flyer "approved" by the Department. It contains a statement that the insurer and

the agent involved in the solicitation are not connected with the Medicare program that the prior flyer did not. While the statement is set in smaller type, it is still prominent and readable. Like the "approved" flyer, there is no specific statement that it is for insurance or intended to obtain insurance prospects, but it does state the full name of AFLAC, which fairly implies that an insurance company is involved. The flyer does not state that the information will be delivered by a representative of the insurer, but again, that was not a sufficient basis for the Department to disapprove the flyer previously. Even though the Department does not "approve" a flyer, Licensee was somewhat justified in relying on the prior directions given to him by the Department and substantially complied with those directions with his new senior citizen meeting notice. The flyer is in violation of the rule, but under these circumstances, that violation does not constitute grounds for discipline.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

## RECOMMENDATION

IT IS RESPECTFULLY RECOMMENDED that the Commissioner of Commerce take disciplinary action against the insurance agent's license of Raymond R. Rew.

Dated this 24th day of September, 1990.

STEVE M. MIHALCHICK
Administrative Law Judge

## NOTICE

Pursuant to Minn. Stat. 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

Reported:

## MEMORANDUM

The burden of proof is upon the Department to prove the facts at issue by a preponderance of the evidence. Minn. Rule 1400.7300, subp. 5; In re Schultz, 375 N.W.2d 509 (Minn. App. 1985). In professional licensing cases where proceedings are brought on behalf of the state attacking a person's professional and personal reputation and character, the gravity of the decision to be made requires the finder of fact to be persuaded only by

evidence "with heft." In re Wang, 441 N.W.2d 488 (Minn. 1989). The Findings

set forth above have been made with those standards in mind.

Where the record shows inconsistencies in a person's testimony and discrepancies between that person's trial testimony and deposition, the fact-finder is justified in concluding that the person is an unreliable witness and the testimony in those regards is not to be believed. On the other hand, it has been held that in sorting through a series of statements in which specific details vary, "[t]he credibility of a witness is not necessarily destroyed so as to render his entire testimony unworthy of belief

Nelson v. Nelson, 166 N.W.2d 70, 74 (Minn. 1969). The question turns on whether the statements are conclusively inconsistent or contradictory since it cannot be expected that statements made at different times and under different circumstances must conform in every detail. id. If they did, one could be justifiably suspicious. Witnesses who are attempting to recall events in a stressful situation may well make statements that are inconsistent and conflicting. In those situations, this is more "a sign of the fallibility of human perception" rather than proof of false testimony. State v. Nelson, 176 N.W.2d 609, 618 (Minn. 1970).

There were credibility problems with both Licensee and Krienke in this case. While Krienke has nothing financially at stake in this matter, she was very angry about having been "fooled" by an insurance man. She stated at the hearing that she had heard they did that to old people. She was obviously also embarrassed about having, in her mind, been fooled by the insurance man. She was also quite quick to respond to questions; in the affirmative when being led by a friendly questioner and with a "no," or "I don't recall," when she was being cross-examined or asked to go into further detail about something. It is quite easy to imagine that when she returned from the bedroom with the wrong insurance policy and Licensee asked her to go back again, she would have said, "That's all I have." On the other hand, Licensee seemed to have no difficulty filling in details with any justification that came to his mind or in distorting and misstating the facts as he knew them to be. Nonetheless, the evidence does indicate that on some of the critical matters, he did tell the truth. It is fairly clear that he did not see the detailed policy. If he had, he would have known immediately that its term extended until December 30, 1989, and that there would be no way he could justify selling a replacement policy. Licensee is neither stupid nor blatantly dishonest. But he was willing to sell Krienke a policy when he had no reliable information to indicate that her policy was up for renewal. Likewise, he was willing to tell lies when it seemed convenient or helpful.